What factors affect the emotional well-being of newly qualified midwives in their first year of practice?

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The Royal College of Midwives (RCM) reports that between 5–10% of newly qualified midwives (NQM) leave the profession in the UK within a year of registration, with similar losses reported internationally (RCM 2010). NQMs are in a position of vulnerability and are highly susceptible to workplace adversity that subsequently may affect their emotional well-being. This literature review explores the experiences of NQMs surrounding their emotional well-being within the first 12 months of transition.

Following a thorough search and appraisal of the literature, four papers were reviewed. Two key themes were identified consisting of factors that challenge NQMs' resilience causing negative emotional well-being, and factors that enhance resilience, promoting positive emotional well-being.

The findings of this review demonstrate that there is a need for the consistent implementation of protective mechanisms such as structured preceptorship and supportive mentorship. Such interventions may improve physical and emotional well-being, increase retention and better prepare NQMs for the journey ahead; ultimately also improving quality of care for women and patient safety.

Keywords: Newly qualified midwife, confidence, experiences, resilience, well-being, transition.

Introduction

Midwives are currently placed under pressure due to the rising birth rate (Royal College of Midwives (RCM) 2016), increasing numbers of women presenting in pregnancy with complex social and physical care needs (Hunter & Warren 2014, RCM 2017) and a national shortage of midwives (Warwick 2012, RCM 2017) subsequently leading to stress and burnout in the midwifery profession (Yoshida & Sandall 2013). The RCM reports that between 5–10% of new midwives leave the profession in the UK within a year of qualifying (RCM 2010), with similar losses reported internationally (Fenwick *et al* 2012). Newly qualified midwives (NQMs) are in a vulnerable position and are therefore highly susceptible to workplace adversity (Hunter & Warren 2014).

Resilience is defined by Rutter (1999) as a relative resistance to adversity. Working cross sector in a new unfamiliar environment can adversely affect the adaptability of NQMs due to

uncertainties of their role (Hunter 2004, Hughes & Fraser 2011, Avis *et al* 2013). A recognised strategy to ensure retention of midwives and NQMs within the profession, is to empower them with the tools to protect their own emotional well-being by creating resilience (Deery 2005, Kirkham *et al* 2006).

Emotional well-being is difficult to define and multifactorial. Dixon *et al* (2017) define emotional well-being as 'psychological well-being'. The Mental Health Foundation (https://www.mentalhealth.org.uk/) defines it as good mental health and a positive sense of well-being. Murthy (2016) describes it as an inner resource allowing resilience and strength in the face of adversity. For the purpose of this literature review 'emotional well-being' is defined as the experience of a meaningful life, being able to work productively and coping with daily stresses (Coyle *et al* 2014).

The level of safety and quality of care that women receive is directly correlated to a midwife's well-being (Pezaro 2016), demonstrating that this review topic is both relevant and important. Distressed midwives often have impaired cognitive function affecting compassion and decision making (Beaumont *et al* 2016). Reviewing studies of NQMs' experiences in their first 12 months can identify factors affecting their well-being which could be utilised to create support interventions. Priorities should be given to enhance well-being and build resilience, readying NQMs for their professional journey.

Background

There is a plethora of literature addressing newly qualified nurses' (NQNs) transition into the workforce and their emotional well-being (Chana *et al* 2015, Smith & Yang 2017). Less literature exists for the same experiences of NQMs; therefore nursing literature which is transferrable to midwifery, is also explored within this appraisal of the current working environment. Historic seminal work by Kramer (1974) describes NQNs experiencing a 'reality shock' when adjusting to the workplace, arguing that their pre-registration nursing education had given them unrealistic expectations. This theme of reality shock persists today and is the key reason why NQNs leave (Al-Hussami *et al* 2014).

Newly qualified practitioners report a 'theory-practice gap', describing the dichotomy between theory learnt at university and the reality of practice (Newton & McKenna 2007). Midwives describe a dissonance between learning about woman-centred care at university and the reality of clinical practice constraints and expectations (Seibold 2005, Licqurish & Seibold 2008). Frustration and inability to practise in the way they wish is a key reason for midwives leaving the profession (RCM 2015).

Midwife shortages and inadequate, unsustainable working conditions with chronic understaffing cause midwives to become stressed and burnt out (Warwick 2012, Hunter & Warren 2013, Byrom 2016). This is a difficult working environment for NQMs to be entering into. The midwifery culture of giving 100% or more to prove their worth is a positive attribute in the midwifery workforce but can be used negatively to persuade compliance to institutional needs. Midwives work long shifts with little or no breaks due to heavy workloads, which has been termed 'service and sacrifice' (Kirkham 1999).

The Francis report (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013) describes a culture of bullying within the National Health Service (NHS) hierarchies. Bullying is not only detrimental to the individual and the institution but also has a negative impact on the care of service users. NQMs may struggle and feel overwhelmed by their lack of confidence to practise autonomously (Avis *et al* 2013). Access to support from colleagues is essential for creating confidence and sustaining resilience for NQMs (Hunter & Warren 2014). NQMs require investment to enable focused, supported learning and nurturing by experienced midwives promoting role modelling (Hart *et al* 2007, McDonald *et al* 2012).

There is little research concerning the experiences of NQMs during the first year of practice following registration; therefore this literature review aims to answer the question, What factors affect the emotional well-being of NQMs in their first year of practice?

Methodology

A systematic search strategy was undertaken enabling identification of relevant published material (Aveyard 2014). An electronic search was also undertaken through both university and external databases to increase the range of literature retrieved (Gomersall & Cooper 2010). Table 1 shows databases searched between December 2016 and January 2017. The PICOS framework (Population, Intervention, Comparator, Outcome and Studies) was used to help the researcher define the individual elements of the research question (Table 2).

Table 1. Data sources.

Databases searched	External databases searched
CINAHL Maternity and Infant Care Medline PsycINFO	Google Scholar TRIP ScienceDirect Cochrane Database of Systematic Reviews

Table 2. Factors affecting NQMs (PICOS framework).

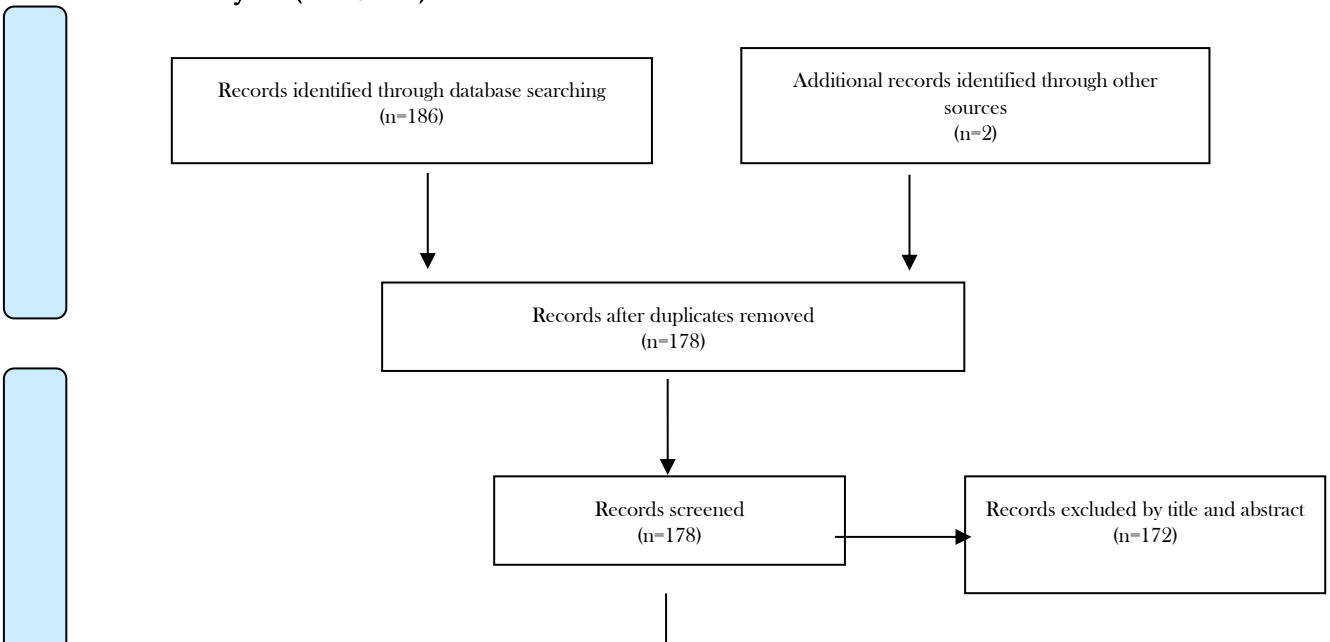
Population	NQMs in transition period (within 12 months) working in the UK, Ireland, Australia and New Zealand
Intervention	NQMs' working environment
Comparison	Not considered necessary
Outcome	NQM well-being
Studies	Primary qualitative research studies of NQMs' experiences in transition in both hospital and community settings

A literature-scoping exercise was undertaken to identify relevant keywords and associated synonyms, including global variations in terms (Brunton *et al* 2017). Literature scoping demonstrated that the term 'newly qualified midwife' was interchangeable with 'new graduate midwife' in Australia and New Zealand; therefore this was added as a keyword. Boolean operators and Medical Subject Headings (MeSH) were searched in addition to keywords. Hand searches were undertaken on reference lists of relevant journal articles (Aveyard 2014).

Figure 1 displays that after the removal of duplicates a total of 178 papers were screened by title and abstract.

Figure 1. PRISMA flow diagram.

Database search results flowchart using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).



One hundred and seventy-two articles were excluded and the remaining six papers were mapped against the inclusion/exclusion criteria (Table 3).

The two papers excluded by review of full text (Avis *et al* 2013, Hughes & Fraser 2011) did not meet the criteria set by the reviewer but were used for discussion elsewhere in the review. An overview of the final studies is shown in Table 4. The internationally recognised Critical Appraisal Skills Programme (CASP) checklist for qualitative studies was used to appraise the quality of the four papers (CASP 2017). Thematic synthesis of the qualitative studies was undertaken identifying two overarching themes.

Table 4. Overview of final studies.

Paper 1	Reynolds EK, Cluett E, Le-May A (2014). Fairy tale midwifery – fact or fiction: the lived experiences of newly qualified midwives. *British Journal of Midwifery* 22(9):660-8.
Methodology	Qualitative interpretive phenomenology in van Manen's perspective.
Methods	Three semi-structured face-to-face interviews, first one held at university, then at four and 12 months, digitally recorded and transcribed verbatim.
Sample	Purposive sampling of 12 NQMs, aged 18–45 and from different ethnic, social and cultural backgrounds in UK
Results/findings	**Reality shock** – Felt shocked and disappointed once the reality of midwifery failed to measure up to their ideals and self-made expectations. Heavy workloads. Anxiety of 'being on own'. Felt unprepared for real world of clinical practice. **False promises** – Idealistic perception of the midwife role and false expectations of midwifery relating to the work they would be expected to do and the relationships that they would have with others. Lack of staff and/or support, preceptorships not being what they thought. **Being part of the club** – To survive meant being accepted by the team. Felt they had to impress and prove themselves. **Self-doubt** – Confidence was knocked when having to cover shifts in unfamiliar areas. Expected within the first few weeks of qualifying to be the only qualified midwife in a busy high-risk ward. Assuming responsibility. Felt under-valued. **Struggling –** Suffered from anxiety and lack of self-belief. Negative and positive feelings of the role. **Beyond competence** – Responsibility remained the participant's biggest cause of anxiety. Struggled with feeling devoid of autonomy, advocacy and decision making.
Paper 2	Hobbs JA (2012). Newly qualified midwives' transition to qualified status and role: assimilating the 'habitus' or reshaping it? *Midwifery* 28(3):391-9.
Methodology	Qualitative ethnographic study with a reflexivity approach.
Methods	Observant participation and semi-structured interviews in the field over three phases. Researcher kept a field diary to take into account her own perceptions and interactions with participants.
Sample	Non-probability sampling method of seven NQMs in the UK.
Results/findings	**Hanging on in –** Participants felt unprepared, in at the deep end and a reality shock of the role of the midwife not being what they expected. **Fitting in to the midwifery culture –** Conflict and competition (dog eat dog) and then starting to fit in by 'playing the game'. Service and sacrifice – to gain respect by staying after your shift or going without or having short breaks, considered a way to fit in. **Determining what type of midwife they wanted to be –** Being with the woman and challenging the old-school midwives with entrenched viewpoints.
Paper 3	van der Putten D (2008). The lived experience of newly qualified midwives: a qualitative study. *British Journal of Midwifery* 16(6):348-58.
Methodology	Qualitative approach using Heiderggerian phenomenology.
Methods	An initial in-depth 1-1 interview with interview guides, and tape recorded. Then once the data analysis was in final stages, the researcher returned to participants for a final interview to validate the findings.
Sample	Purposive sample of six NQMs who had all qualified within the previous six months in Ireland.
Results/findings	**Reality shock** – NQMs felt insecure and fear in fulfilling their new role. Felt overwhelmed and vulnerable. **Feeling prepared** – They unanimously felt well prepared theoretically but felt unprepared for the real world of clinical practice. **Living up to expectations** – NQMs were aware of increased expectations of women and their families as being stressful. **Theory-practice gap** – Conflicting ideologies. Lack of confidence to speak up as an advocate for the women. **Clinical support and mentorship** – Identified the importance of good clinical support for NQMs and the

	need for preceptorship as important. **Continuous professional education** – Their level of responsibility stimulated an awareness of the importance of continuing professional development in order to provide safe care for women.
Paper 4	Fenwick J, Hammond A, Raymond J *et al* (2012). Surviving, not thriving: a qualitative study of newly qualified midwives' experience of their transition to practice. *Journal of Clinical Nursing* 21(13-14):2054-63.
Methodology	Qualitative descriptive approach.
Methods	Tape recorded in-depth 1-1 interviews and as analysis progressed other questions were added. Transcribed verbatim.
Sample	A convenience sample of 16 NQMs from two preregistration educational programmes from same university but over two years (eight from direct entry degree and eight were already nurses who had completed 18 month course) in Australia.
Results/findings	**The pond** – Midwifery culture with a hierarchical system and hectic chaotic understaffed environment with unmanageable workloads. Poor or lacking support. Institution *vs* woman-centred care. Told to 'get on with it' and 'toughen up'. **Life-raft** – Some relationships with inclusive midwifery colleagues who willingly shared their knowledge and were positive had a powerful effect on either facilitating or hindering confidence levels. Negative or inhibitory midwifery behaviours. **Swimming** – Gaining confidence and competence from positive relationships with colleagues and a supportive environment. **Sinking** – Poor relationships with midwives and a difficult working environment.

Findings

Two main themes emerged containing several further subthemes.

Theme 1: Factors which challenge resilience and cause negative emotional well-being: working conditions and environment.

All papers identified heavy workloads, a busy environment and staff shortages as key issues. Covering shifts due to staff sickness and rotation caused NQMs pressure and anxiety. NQMs described a perceived lack of support making them feel pressured, out of control and panicked (Fenwick *et al* 2012). Working 14 and a half-hour shifts with a ten minute break due to heavy workloads is described by one NQM as causing stress (Hobbs 2012). Staffing issues exacerbated an already busy environment in which NQMs struggled to give quality care to women causing feelings of guilt and frustration (van der Putten 2008). NQMs felt exhausted, frustrated and stressed due to working long shifts (Reynolds *et al* 2014).

Reality shock/theory-practice gap

In all papers NQMs described experiencing a reality shock on entering the workplace, experiencing negative feelings of frustration and disappointment and some feeling unprepared on entry to clinical practice (van der Putten 2008, Reynolds *et al* 2014).

NQMs experienced the conflicting ideology of being taught woman-centred care at university and the reality of working autonomously within an environment where the medical model of care dominates. Subsequently, NQMs felt guilt and emotional distress at not being able to give woman-centred care (van der Putten 2008, Fenwick *et al* 2012, Hobbs 2012). Frustration was also felt at women being perceived as commodities (Fenwick *et al* 2012).

Further to this, guilt and emotional distress was caused by NQMs' lack of confidence to speak up and be the woman's advocate (van der Putten 2008, Fenwick *et al* 2012). All studies described NQMs feeling confused and struggling with senior midwives' attitudes towards intervening with women's labours. They were frustrated by their lack of autonomy and its effect on the women in their care, when taught at university to empower women to make their own decisions.

Responsibilities of the role

Two studies identified how new-found responsibility caused NQMs to feel stressed, frightened and anxious (van der Putten 2008, Reynolds *et al* 2014). One paper described physical manifestations of stress such as abdominal pain (Fenwick *et al* 2012). Other midwives' negative attitudes and expectance for NQMs to cope with responsibility made NQMs feel anxious and alone (Fenwick *et al* 2012, Reynolds *et al* 2014). However, some NQMs adapted and the new-found responsibility provided them with a learning curve that forced them to use their autonomy (Reynolds *et al* 2014).

NQMs also described fear of disappointing women in their care and worrying about not being able to facilitate perfect births or live up to women's expectations of a midwife (van der Putten 2008).

Midwifery culture and identity

NQMs were acutely aware of being at the bottom of a midwifery hierarchy which made them feel worthless and undervalued by some mentors and preceptors (Fenwick *et al* 2012, Hobbs 2012). They describe being ill but still going into work, not taking a break or taking a short break and feeling a need to belong by proving their worth and commitment (Hobbs 2012). NQMs described the need for acceptance into the team by going above and beyond to prove themselves (Reynolds *et al* 2014).

Feeling unsupported

Lack of support from other midwives, which was seen as a detrimental factor to their emotional well-being during transition, was featured in three studies (Fenwick *et al* 2012, Hobbs 2012, Reynolds *et al* 2014). NQMs described knowing who to ask for help and who to avoid, with intimidation linked to senior midwives (Hobbs 2012, Reynolds *et al* 2014).

Perceived bullying is described by one NQM as having a finger pointed in her face by another midwife (Fenwick *et al* 2012). Other NQMs describe humiliation and passive aggressive

behaviour expressed to them when they required support causing them feel guilt, excluded and to lose confidence (Fenwick *et al* 2012). Hobbs (2012) describes NQMs having to learn to adapt to certain senior midwives' attitudes making them question if they were in the right career.

Theme 2: Factors which build resilience and sustain positive emotional well-being: positive relationships with midwives and women.

All studies feature positive relationships with mentors, other midwives and women as being a critical factor in their transition in the first twelve months. Positive support by a mentor provided NQMs with reassurance and safety giving them confidence, promoting better performance and competence and making them feel valued at having a positive learning experience (van der Putten 2008, Fenwick *et al* 2012). In comparison the NQMs in the study by Reynolds *et al* (2014) did not fully understand or value the supernumerary aspect of preceptorship periods which were offered to smooth their transition. Building a great rapport with women and being able to be 'with woman' and support her throughout labour made NQMs feel that they had made a positive difference to her experience that produced feelings of satisfaction (Hobbs 2012).

Positive role models and practising women-centred care

Three studies describe NQMs having positive feelings when working with midwives who are midwifery focused, and even though working within a medicalised environment are still providing woman-centred care (van der Putten 2008, Fenwick *et al* 2012, Hobbs 2012). This positive role modelling of midwives created satisfaction and a positive identity in the NQMs (Hobbs 2012).0

Discussion

Reality shock experienced by NQMs in transition was apparent in all papers and is supported in previous nursing and midwifery literature (Kramer 1974, Duchscher 2009, Hughes & Fraser 2011, Al-Hussami *et al* 2014). This demonstrates that reality shock is not a new phenomenon, even though the NHS is perceived to be working under greater constraints than ever before. It could be argued that reality shock is a normal part of the transition process and that the intervention required is to support this process.

Crow & Hartman (2005) argue that newly qualified practitioners can become disillusioned with their new role if unsupported in their transition to practice, making them more likely to leave. Evidence proves the effectiveness of preceptorship packages in midwifery (Whitehead *et al* 2016) but unfortunately provision and quality of preceptorship is variable due to the lack of statutory requirement and emphasis on employers to manage the transition. NQMs require investment to enable focused, supported learning and to be nurtured by experienced midwives promoting role modelling (Hart *et al* 2007, McDonald *et al* 2012, Avis *et al* 2013, Hunter & Warren 2014). Avis *et al* (2013) suggest it is crucial for midwifery managers to provide tailored support for NQMs by allocating 'around the clock' clinical support to their first rotation. The scheduling of experienced midwives ready and willing to be supportive and work side-by-side with NQMs is crucial.

Two review papers found that role responsibilities caused NQMs to feel stressed and anxious which is reiterated in other literature (Hobbs & Green 2003, Avis *et al* 2013). This could be addressed by working in collaboration with the Nursing and Midwifery Council (NMC) and pre-registration educators to develop an undergraduate curriculum that facilitates students to gain more complex care and leadership skills required for practice in addition to 'with woman' midwifery skills (Skirton *et al* 2012, Schytt & Waldenstrom 2013).

All papers described the theory-practice gap resulting in frustration, disappointment and stress. Midwives and NQMs who learn to overcome adversity and adapt become more resilient which then becomes protective (Lyons *et al* 2009, Hunter & Warren 2014). Experiences of being over-ruled by senior midwives in the care they gave to women appeared in all four review papers but this issue is not unique to NQMs. Both Leap (2010) and Walsh & Downe (2010) have written about hierarchies, power and attitudes in midwifery. Hunter & Warren (2014) found that positive relationships with women and midwives are essential for creating resilience, supporting the findings of this review where NQMs have described the positive effect of good relationships in the workplace.

The themes emerging from this review concur with findings from historically-published literature, demonstrating that the same issues persist and although decades have passed, no effective solutions have been implemented. All papers described environmental and working conditions as factors which affect emotional well-being, supporting the issues raised previously by authors (Sandall 1997, Hunter 2004, Kirkham *et al* 2006). Pressure and stress felt by NQMs

on rotation and covering shifts due to sickness was also evident in all papers. Avis *et al* (2013) challenge that this is negative as NQMs who experience a lack of familiarity on rotation to different areas are forced to take the initiative in developing autonomy which in turn builds confidence.

Negative workplace issues and the effect on well-being for all staff is acknowledged by the RCM in their 'Caring for you' campaign, aiming to improve midwives' health, safety and well-being in the work environment (RCM 2016). It will be interesting to see if the impact of this campaign is effective in helping NQMs who describe distinct issues unique to the NQM transition period.

Conclusion and recommendations

This literature review demonstrates that there are both positive and negative factors that affect emotional well-being during the first year of qualified midwifery practice. Negative factors were predominant in the experiences reviewed but contrasting this evidence with previously published literature shows that factors such as reality shock, theory-practice gap and issues with working conditions are historic in nature. It is argued by the reviewer that some issues, particularly reality shock, may be both a natural and reasonable response to the transition from student to autonomous midwifery practitioner. Theory-practice gaps have potential to be narrowed if universities, the NMC and the NHS are able to work collaboratively in supporting both students and newly qualified practitioners to be competent and confident to work in today's NHS environment. The review suggests that comprehensive and consistently delivered preceptorship packages may improve the emotional well-being of NQMs, demonstrating that NQMs value positive relationships and support from more experienced midwives.

This review is based on the final stage project of a sole undergraduate midwifery student which is acknowledged as a limitation and a factor affecting the reliability and validity of the review findings. Further research is required in this topic area with a larger funded midwifery research team. More research is needed in this area to investigate why some NQMs cope well, and some do not, in their experience of transition to practice in the first year after qualification.

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